



Midwest Brain & Spine, LLC
3400 Dexter Ct, Suite 200
Davenport, Iowa 52807
(563) 344-8330
(563) 344-8339 fax

Financial Agreement

Whether signing as the patient or his/her agent, I agree that in consideration of the services to be rendered, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT IN ACCORDANCE WITH THE REGUALR RATES AND TERMS, even in the event that my insurance company denies payment. I shall also be responsible for any deductibles, co-pay or coinsurance owed at the time of service. I understand that I am financially responsible for charges not covered by this assignment. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney’s fees and collection expenses. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, Midwest Brain & Spine may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of charges (including but not limited to insurance companies, health service plans, or worker’s compensation).

I hereby certify that the information given by me in applying for payment under Medicare, Medicaid, or any other payer is correct. I assign all benefits due me under the terms of said policies and programs. A photostatic copy of this assignment shall be considered effective and valid as the original.

I understand that, as a courtesy, Midwest Brain & Spine will file my primary insurance. After 60 days from the date of service, the total balance will be considered due and payable. I understand that any discussions of insurance benefits between myself and representatives from Midwest Brain & spine are estimates only and that I am ultimately responsible for the balance of my account.

I understand that patient balances not paid within 30 days of the date of the first statement may draw late charges of 1½% per month until paid in full. (The patient balance is the patient payment responsibility AFTER applicable insurance payment has been received by Midwest Brain & Spine).

Initial: _____

I understand that a fee of \$25.00 will be assessed on all returned checks, including but not limited to, checks returned for insufficient funds.

I understand that I may receive additional bills from separate entities, related to my surgery or procedure that I am financially responsible for, including but not limited to, physician/surgeons, anesthesia providers, durable medical equipment, pathology tests, labs or other tests related to my surgery.

Initial: _____

Signature of Patient/Guardian

Date

Signature of Witness

Written Name of Patient